MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13652 Item 8 FilmG257 1-12-59 et 13643

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md
c. LENGTH OF STAY IN 1b: Unknown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: River Vtew Village Indian Head Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alfred Middle: Charles Last: Clark

4. DATE OF DEATH: Month: 12 Day: 31 Year: 58 19

5. SEX: Male

6. COLOR OR RACE: White US

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-27-12 1912

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Powder worker

10b. KIND OF BUSINESS OR INDUSTRY: US Govt.

11. BIRTHPLACE (State or foreign country): Cherry Hill Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown Alfred W. Clark

14. MOTHER'S MAIDEN NAME: Unknown Bassie Love

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 718-16-9792

17. INFORMANT: Official Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Injuries Multiple Extreme — INTERVAL BETWEEN ONSET AND DEATH: Immediate

919.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Explosion

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was working at the Naval Poder Factory Indian Head where there was an explosion killing him instantly

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Explosion at the Naval Powder Factory Indian Head Md

20c. TIME OF INJURY Hour: a.m. 12-31-58 p.m. 11-2[illegible] Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory

20f. (City or town) Indian Head Md. (County) Charles (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James E. Andrews MD

EXAMINER'S NAME (Type): James E. Andrews MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: ~~Jan 58~~ 1-1-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 3, 1959

22c. NAME OF CEMETERY OR CREMATORY: Pohick Cem.

22d. LOCATION (City, town, or county) Pohick (State) Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The Hunter Funeral Home, Waldorf Md.

ADDRESS:

24a. REC'D BY REGISTRAR DATE: JAN 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil as Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

X

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13644

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Doncaster
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle EDWARD Last DAY

4. DATE OF DEATH: Month 12 Day 24 Year 1958

5. SEX: M

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 15, 1918

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William J Day

14. MOTHER'S MAIDEN NAME: Maggie Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: William J Day Bryans Road Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 2 min.

825 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Crush Injuries, Right Chest — 2 min.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Highway Auto Accident - Rt. 224

20c. TIME OF INJURY: Hour 11:50 p. m. Month, Day, Year 12-24 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Doncaster, Charles, Md.

21. I certify that I took charge of the remains described above, held an autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: /s/ V. B. Dettor M.D.

EXAMINER'S NAME (Type): V. B. DETTOR

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ACT. DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 25 Dec, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/29/58

22c. NAME OF CEMETERY OR CREMATORY: Pomfret Catholic Church

22d. LOCATION (City, town, or county) (State): Pomfret, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Johnson & Jenkins

ADDRESS: 4804 GA. Ave. N.W.

24a. REC'D BY REGISTRAR DATE: DEC 31 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13645

13654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK POINT
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: WEBSTER J. EDELEN

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 1958

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1913

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Oysterman

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Edelen

14. MOTHER'S MAIDEN NAME: Maggie Owen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 229-16-8900

17. INFORMANT: Address: Edward Edelen Rock Point Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12-23-58

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 1956

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E J Edelen M.D.

EXAMINER'S NAME (Type): E. J. EDELEN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 12-23-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/26/58

22c. NAME OF CEMETERY OR CREMATORY: Holy Ghost

22d. LOCATION (City, town, or county): Issue (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Orchard Inc La Plata Md

ADDRESS:

24a. REC'D BY REGISTRAR DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13646

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Waldorf
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil Middle: P. Last: GATES
4. DATE OF DEATH: Month: 12 Day: 26 Year: 1958
5. SEX: M
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1898
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Gates
14. MOTHER'S MAIDEN NAME: Lillie M. Wedding

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Helen Norris, Ardmore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 0
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Massive Coronary artery Occlusion — 0
DUE TO (c): Arteriosclerotic Heart Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occured while sitting and eating
20c. TIME OF INJURY Hour: 5:00 p. m. Month, Day, Year: 12-26 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bar
20f. (City or town) (County) (State): Waldorf, Charles, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: V B Dettor M.D.
EXAMINER'S NAME (Type): V. B. DETTOR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
Act. DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-26-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-29-58
22c. NAME OF CEMETERY OR CREMATORY: St Pauls
22d. LOCATION (City, town, or county) (State): Waldorf Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The Hunt Funeral Home, Waldorf, Md.
ADDRESS:
24a. REC'D BY REGISTRAR DATE: DEC 31 '58
24b. REGISTRAR'S SIGNATURE: Clifton L. Hunt

1

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13651

13642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head	c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Indian Head Md
	d. STREET ADDRESS: 39-Mattingly Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: John M.	Middle: Gray (Case # 6933)	Last	4. DATE OF DEATH ~~123~~	Month: 12	Day: 17	Year: 19 58	
5. SEX: Male	6. COLOR OR RACE: W-US	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 10-30-58	9. AGE (In years last birthday): — yrs.	IF UNDER 1 YEAR: Months / Days 47	IF UNDER 24 HRS.: Hours	Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): USA-District of Columbia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown-Welfare Baby		14. MOTHER'S MAIDEN NAME: Unknown-Welfare Baby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Frank Catrufo Jr-Welfare Home Owner — Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Broncho Pneumonia	2-Hrs
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Cold-Coryza	3-Weeks
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 12-17-58

EXAMINER'S NAME (Type): James E. Andrews MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 12-19/58	22c. NAME OF CEMETERY OR CREMATORY: St Charles	22d. LOCATION (City, town, or county) (State): Klymont Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: Richard Lee Lapleta	ADDRESS	24a. REC'D BY REGISTRAR: DEC 22 '58	24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13647

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorchester
c. LENGTH OF STAY IN 1b: 25 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorchester, Md
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):
e. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JULIA (Nina) Middle: Last: JACKSON

4. DATE OF DEATH: Month: 12 Day: 10 Year: 58 19

5. SEX: Female

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McPherson

14. MOTHER'S MAIDEN NAME: Perkinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: NOBLE JACKSON (Husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331x — Pernicious Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Hypertension — 10 yrs.
DUE TO (c): Arterio Sclerosis — Blood

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES E ANDREWS

DATE SIGNED: 12-10-58

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 12-13-58.

22c. NAME OF CEMETERY OR CREMATORY: Zion Baptist Cem.

22d. LOCATION (City, town, or county) (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Montgomery Bros

ADDRESS: 913 Florida Ave NW

24a. REC'D BY REGISTRAR DATE: DEC 17 '58

24b. REGISTRAR'S SIGNATURE: Arthur E. Power

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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M

C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13648

13657

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY: Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bryans Road

LENGTH OF STAY (In this place): 41 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bryans Road

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Margaret (Last) Jenkins

4. DATE OF DEATH (Month) Dec. (Day) 31 (Year) 19 58

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W	Single	March 25, 1917	41 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Bryans Road, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benedict M. Jenkins

14. MOTHER'S MAIDEN NAME: Mary Eva Coomes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT'S ADDRESS: Benedict M. Jenkins, Bryans Road, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Rheumatic Fever — INTERVAL BETWEEN ONSET AND DEATH: 38 yrs

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B):

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Arthritis deformens — 24 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 43, to Dec. ....., 19 58, that I last saw the deceased alive on Dec. 29, 19 58, and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE: Frank G. Dugan M.D. ADDRESS (Street, city, town, state): Indian Head, Md. DATE SIGNED: 12-31-58

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 2 1959	St. Joseph Catholic	Pomfret Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE JAN 5 '59	[illegible]	Urquhart Inc	La Plata Md

1

FOR STATE HEALTH DEPT.

Item 18 Film 237 [illegible]

13658

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13643

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wayside
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wayside
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Beatrice — Middle: JUPITER — Last: JUPITER
4. DATE OF DEATH — Month: December — Day: 11, — Year: 19 58

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1956
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chas Co Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert Lee Jupeter
14. MOTHER'S MAIDEN NAME: Nellie Wills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or period of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Robert L Jupeter Waysid Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 286.5 — Malnutrition
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.):
20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 12/11/58
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/13/58
22c. NAME OF CEMETERY OR CREMATORY: Shiloh Mem
22d. LOCATION (City, town, or county) (State): Waysville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Richard Lee Stephens
ADDRESS:
24a. REC'D BY REGISTRAR — DATE: DEC 18 '58
24b. REGISTRAR'S SIGNATURE:

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13659 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13650

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mason Springs
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): State Route # 225

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Indian Head
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FOY — Middle: Robinson — Last: PENDERGRAFT
4. DATE OF DEATH: Month: DEC. — Day: 25 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: September 25, 1912
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - U.S. Government
10b. KIND OF BUSINESS OR INDUSTRY: Powder Factory
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irvin Pendergraft
14. MOTHER'S MAIDEN NAME: Ethel (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1930-1939
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: (Uncle) 15- Mr. Henry L. Jansen — Address: Jonquil Place, Potomac Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — Interval between onset and death: 1 Min.
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Crush Injuries, Left Chest — 1 min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Highway Auto Accident
20c. TIME OF INJURY: Hour 8:35 p.m. — Month, Day, Year: 12-25 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): (County): Charles, (State): Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: V B Dettor — M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 12-25-58

EXAMINER'S NAME (Type): V. B. DETTOR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 30, 1958
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: AREHART FUNERAL HOME, INC. * LA PLATA, MD.
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: [illegible] S. Howard

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13660 CERTIFICATE OF DEATH

Reg. Dist. No. 13651

1. PLACE OF DEATH a. COUNTY Charles MARYLAND
2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles
2b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata Md
2c. LENGTH OF STAY IN 1b 3 Days
2c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital
2d. STREET ADDRESS
2e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First VIRGONETTE Middle Last RISEY
4. DATE OF DEATH Month 12 Day 29 Year 58 19
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 4-6-1882
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Charles Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Richard Ferrall
14. MOTHER'S MAIDEN NAME Sarah B.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO None
17. INFORMANT Address Leo K. Ferrall Jr. La Plata Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 Days
420.1
DUE TO (b) Hypertension — 3 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Cerebro Sclerosis - Senile — 3 Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-1-1957 19 to 12-29-58 19, that I last saw the deceased alive on 12-24-58, 19, and that death occurred at 5:45 M, from the causes and on the date stated above.
ACTUAL SIGNATURE James Andrews M.D. ADDRESS (Street, city or town, state) Md. Ave Indian Head DATE SIGNED 12-24-58
PHYSICIAN'S NAME (Type) JAMES E ANDREWS Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/31/58
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill
22d. LOCATION (City, town, or county) Suitland (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hunt Funeral Home, Waldorf, Md.
24a. REC'D BY REGISTRAR DATE JAN 5 '59
24b. REGISTRAR'S SIGNATURE Conrad S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13661

CERTIFICATE OF DEATH

13652

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 ... the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Joseph Middle Gilbert Last ROBERTS

4. DATE OF DEATH: Month DEC Day 20 Year 1958

5. SEX: M

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 5, 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Roberts

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Gilbert Roberts, Hughesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1948, to Dec 20, 1958, that I last saw the deceased alive on Dec 16, 1958, and that death occurred at 3:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Roy Gwyther M.D.
ADDRESS (Street, city or town, state): Mechanicsville, Md.
DATE SIGNED: 12/20/58

PHYSICIAN'S NAME (Type): J. Roy Gwyther Mechanicsville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/23/58
22c. NAME OF CEMETERY OR CREMATORY: St Peters
22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hurst Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: DEC 20 '58

24b. REGISTRAR'S SIGNATURE:

VS A15 (4)
15M 9/55

Item 1 Film 240

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14441

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Occaquan Bay Virginia Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Washington D.C.
c. LENGTH OF STAY IN 1b: 20 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington D.C
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS: 142-12th St. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hartley Middle: Hill Last: Schenck

4. DATE OF DEATH: Month: 12 Day: 15 Year: 19 58

5. SEX: Male
6. COLOR OR RACE: W-US
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-31-92
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Fairfax County, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Henry Schenck
14. MOTHER'S MAIDEN NAME: Anna Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 300-03-7616
17. INFORMANT: Mrs Ida Schenck -Wife Address: 142-12St SE. Wash-D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fatal Submersion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Accidenttal
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 850x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Was on a boat that foubdered
20c. TIME OF INJURY: Hour 7-30 o. m. p. m. Month, Day, Year 12-15-58 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, office bldg., etc.): Occaquan Bay
20f. (City or town) Fairfax County (County) Va. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3-22-59
EXAMINER'S NAME (Type): James E. Andrews, Indian Head Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3/23/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Faith Funeral Home
ADDRESS: 741-11th St. S.E. R. A. Nash 1252
24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2. 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG241 4-24-59 et

13662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG237 1-15-59 et

14427

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head, Md.
c. LENGTH OF STAY IN 1b: Unknown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Tobacco
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Austin — Last: Thomas
4. DATE OF DEATH: Month: 12 — Day: 31 — Year: 19 58
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ (Married)
8. DATE OF BIRTH: 9-20-20
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Powder Factory Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): US Army
16. SOCIAL SECURITY NO.:
17. INFORMANT: Official Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries Extreme — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
916.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Explosion
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Was working at the Naval Powder Factory Indian Head Md. Where there was an explosion killing him instantly
20c. TIME OF INJURY: Hour: 11-27 o. m. p. m. — Month, Day: 12-31-58 — Year: 19
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory
20f. (City or town) Indian Head Md (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): James E. Andrews MD Indian Head Md.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 1-1-59

Certified to be a true Copy
James E. Andrews MD

22a. BURIAL, CREMATION, REMOVAL (Specify): 1/14/59
22b. DATE THEREOF:
22c. NAME OF CEMETERY OR CREMATORY: Hillton Md.
22d. LOCATION (City, town, or county) (State): Hillton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Johnson & Jenkins — ADDRESS: 4804 Ga. Ave. Nrd.
24a. REC'D BY REGISTRAR DATE: JAN 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hearn

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653

13663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M D. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Waldorf - Rural
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

66

3. NAME OF DECEASED (Type or print): First James — Middle A. — Last YATES

4. DATE OF DEATH: Month 12 — Day 24 — Year 1958

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1886

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: UNK

14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Amanda Yates, Waldorf, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Infarction — 3 days

DUE TO (c): Generalized Arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign Prostatic Hypertrophy with obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: No injury 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no injury

20f. (City or town) (County) (State): LaPlata, Charles, Md.

21. I certify that I attended the deceased from August 1957 to 12-24, 1958, that I last saw the deceased alive on 12-23, 1958, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: V B Dettor M.D. — ADDRESS (Street, city or town, state): La Plata, Md. — DATE SIGNED: 12-26-58

PHYSICIAN'S NAME (Type): V. B. DETTOR

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-29-58

22c. NAME OF CEMETERY OR CREMATORY: St Peters

22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hurtt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 31 '58

24b. REGISTRAR'S SIGNATURE: Orrina S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55